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HENRY CLAYPOOL, CO-DIRECTOR

ADVANCING INDEPENDENCE

ON

"FRAUD AND ABUSE IN THE POWER WHEELCHAIR PROGRAM"

BEFORE THE

SENATE COMMITTEE ON FINANCE

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Good morning, Chairman Grassley, Senator Baucus, and other Committee members. Thank you for inviting me to testify today. I am Henry Claypool, the Co-Director of Advancing Independence, a policy forum that advances responsible reforms in Medicare and Medicaid to increase the health, independence, and self-sufficiency of Americans with disabilities of all ages. I am also a former Medicare beneficiary who is acutely aware of the strengths and severe limitations of the program coverage of manual and power wheelchairs.

The focus of this hearing is on what can be done to curb fraud and abuse in Medicare's purchasing of power wheelchairs. Developing more effective ways to do this is something that we all support. But, we believe this must be done without barring beneficiaries from obtaining the medically necessary wheelchairs they need to move about their homes and communities safely and independently. Unfortunately, CMS is acting as if the only way it can combat fraud is to severely limit the benefit in ways that undermine the health, independence and dignity of thousands of beneficiaries of all ages. We believe that this is wrong and will prove extremely costly to the Trust Funds.

Confusion regarding the wheelchair benefit arises from two key factors. The first is there is a complete lack of clear, up to date clinical standards set by Medicare for determining who needs a manual or power wheelchair. The second is CMS is instead using an overly restrictive interpretation of the statutory phase "used in the patient's home" to limit when Medicare will buy a wheelchair for someone. Congress used this phrase when it created the DME benefit to make certain that Part B paid for such equipment only when the person was living at home, so as not to duplicate payments for persons when they were in a hospital or skilled nursing facility and Part A would cover it.

But, CMS has long had a far more restrictive interpretation of what the phrase means in regard to when Medicare will pay for a manual or power wheelchair. And, it's becoming far more restrictive with each passing day. Today, Medicare will only buy a wheelchair for someone when the person: 1. Is "bed or chair bound"; and 2. Needs that specific wheelchair to move about within the 4 walls of their home.

At first glance, this may seem like a reasonable coverage policy that meets the needs of beneficiaries and helps promote the integrity of the program. Let me highlight why this is not the case by sharing with you snapshots of how this policy has impacted 3 former and current beneficiaries and countless more as well.

My personal experience with Medicare: I had Medicare coverage from 1984-1994 after I sustained a spinal cord injury in college. Back then I was eligible for both Medicare and Medicaid. I was fortunate to have Medicaid, which filled some of the coverage gaps in Medicare benefits. Medicare would only pay for a standard manual wheelchair that was suitable for use in my home. Without Medicaid paying for a sturdier, yet lightweight, manual wheelchair that enabled me to move about the hilly campus of the University of Colorado I would not have finished my education.

I eventually returned to work, left the Medicare and Medicaid rolls and several years later went to work for HCFA Administrator Nancy-Ann DeParle. It was when I was at HCFA that I obtained my power wheelchair using my private coverage. I did so because I needed it to go to work and because my shoulders would soon wear out from over exertion. Had I been on Medicare at the time, the claim likely would have been rejected because I do not need a power wheelchair to move about the four walls of my home. Mr. Chairman, you were one of authors of the Ticket to Work Act. I would respectfully ask that you reflect upon whether it was your or others' intent to extend Medicare coverage as an incentive to return to work only to have the program deny the wheelchair they need to get out the door.

April: April is an elderly woman with Chronic Obstructive Pulmonary Disease (COPD), and has had a portion of her lung removed. She requires continuous oxygen therapy; all day every day, but lives independently in own home. She drives her own car but has difficulty walking the distances necessary to complete the tasks that allow her to live at home. She has been unable to get to the grocery store to complete her shopping for past four months and relies on others to go purchase the food she needs for meals. When she drives to doctor's appointments, she waits in the car until someone brings an office-owned manual wheelchair out to her car to push her into the office. Medicare will not buy April a wheelchair because she does not need one within the 4 walls of her house.

Linda: Linda has Multiple Sclerosis. Her symptoms wax and wane. Most days Linda can walk from her bedroom to the bathroom, to the kitchen the whole time using the walls and furniture to steady herself as she moves from room to room in her 750 square foot apartment. On other days she is hardly able to make it from her bedroom to the bathroom. If Linda lived in a larger home, she might qualify for a wheelchair since she cannot use walls and furniture to steady herself to move about a larger home. Then again she might not.

CMS considers it an abuse for a beneficiary to use Medicare to obtain an appropriate wheelchair even when their physician certifies that it is medically necessary for them to use to move about safely and independently both in their home and community. Mr. Chairman, the agency cannot possibly curb fraud and abuse so long as it continues to assume that its major tool in doing so is to enforce a coverage policy that completely ignores the medical and very practical needs of people who use wheelchairs.

We have 4 brief recommendations that I can share now or hopefully during the question and answer period on what Medicare can do to better fight fraud and abuse without harming beneficiaries.

Recommendations:

1. CMS should immediately initiate a process for working with people with disabilities, physicians, clinicians, industry and others to develop a fair and rational coverage policy that ensures beneficiaries with legitimate medical needs have access to wheelchairs for use in their homes and communities and addresses the issue of combating fraud.

2. Any new national coverage policy should include objective medical standards developed by clinicians that specialize in conducting evaluations of people with functional limitations that arise from disability or the aging process. These standards should be consistent with contemporary standards of medical practice.

3. If CMS believes it is not able to carry out the first two recommendations because it views the statute as not permitting such actions, it should report to this Committee on what the basis of its interpretation for this is.

4. I am attaching to my written comments, a legislative history of the Medicare DME submitted to CMS 3 years ago on behalf of several organizations in follow up to the President's New Freedom Initiative. This history calls the agency's interpretation into sharp question. CMS said it would address these claims but it never has. I respectfully request that this Committee find out why not.

Thank you for this opportunity to raise these critical points, I look forward to answering any questions you might have.